DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL RECORDS MAINTENANCE, ORGANIZATION, AND CONTENTS	**104.08**	**10/16/2012**	**1 of 7**
APPROVED BY: Director	SUPERSEDES **104.8 4/15/05**	ORIGINAL ISSUE DATE **9/1/2004**	DISTRIBUTION LEVEL(S) **2**

PURPOSE

1.1 To provide Directly-Operated programs policy and procedures related to the maintenance, organization, and contents of the Clinical Record for all specialty mental health services provided by the Los Angeles County-Department of Mental Health (LAC-DMH) regardless of payer source.

1.2 To provide a policy to Contract Provider programs related to the maintenance, organization, and contents of the clinical record. **Contract Providers must create their own procedures related to clinical records**.

DEFINITIONS

2.1 **Billing Provider:** A distinct service delivery setting with a unique 4-digit identifying number and program name within the LAC-DMH Integrated System (IS) under which the program establishes episodes, identifies clients, and submits claims to the State's reimbursement system, and has a unique organizational national provider identifier number within the National Plan and Provider Enumeration System (NPPES).

2.1.1 **Reporting Unit:** Billing Providers may have one (1) or more associated Reporting Units represented by an alphabetic character attached to the 4-digit identifying number which designates or distinguishes either the mode of service being delivered at the Billing Provider or a unique service site.

2.2 **Chart Order:** A listing of clinical documents and their location within the Clinical Record.

2.3 **Clinical Record**: The official record containing all clinical information and services related to a client.

2.3.1 **Paper Clinical Record**: The official record containing all clinical information and services related to a client stored on paper/hard copy.

2.3.2 **Electronic Health Record (EHR):** The official record containing all clinical information and services related to a client in an electronic format and stored in an electronic database.

2.4 **Clinical Forms Inventory:** For Directly-Operated programs, a listing of all LAC-DMH approved clinical forms that may be used, without alteration, in the clinical record with the latest revision date(s). For Contract Providers, the Clinical Forms Inventory includes the clinical forms with the latest revision date(s) as well as the type of forms which are listed below. (Reference 2)

The clinical record requirements are applicable in a paper-based and EHR format.

2.4.1 **LAC-DMH Required Clinical Record Forms:** Forms which must be used without alteration.

2.4.2 **LAC-DMH Required Data Elements Clinical Record Forms:** Forms which contain data elements that Contract Providers must collect, as applicable to the situation.

2.4.3 **LAC-DMH Optional Clinical Record Forms:** Forms designed to capture a specific category of information (as indicated by the title and data elements of the form) that Contract Providers must also address, as applicable to the situation, although not necessarily through the use of the exact form.

2.4.4 **LAC-DMH Ownership Clinical Record Forms:** Forms that require specific information in compliance with applicable federal, State, and local laws, regulations, codes, policies and procedures. Because the content of these forms carry potential legal implications, Contract Providers must implement the concepts/principles associated with these forms through their own understanding/interpretation of the applicable authority.

2.5 **LAC-DMH Approved Clinical Forms:** Clinical forms approved by the Quality Assurance Division of LAC-DMH.

2.6 **Extensible Markup Language (XML) Message**: LAC-DMH defined message in XML that corresponds to the clinical data captured in the LAC-DMH required clinical forms and makes the electronic data compatible between data systems.

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL RECORDS MAINTENANCE, ORGANIZATION, AND CONTENTS	**104.08**	**10/16/2012**	**3 of 7**

POLICY

3.1 Directly-Operated staff must comply with the provisions of the LAC-DMH Clinical Records Guidelines (Guidelines) manual which specifies procedures for the proper organization and maintenance of client based records and the disclosure of Protected Health Information (PHI). These provisions are based on federal, State, and local laws and regulations including Health Insurance Portability and Accountability Act (HIPAA) Privacy and Welfare and Institutions Code 5328, as well as accepted standards of professional practice. (Reference 3)

3.2 Contractors of LAC-DMH are not subject to the provisions of the Guidelines manual but are subject to their own relevant policies and all applicable provisions of federal, State, and local laws and regulations including HIPAA Privacy and Welfare and Institutions Code 5328, as well as accepted standards of professional practice.

3.3 All billing providers must maintain a clinical record of all information related to the services provided to a client in accord with DMH Policy Nos. 104.09 and 104.10. (References 4 and 5)

3.3.1 Consistent with contract language, the clinical record must be accessible within three (3) business days for inspection, review and/or audit by authorized representatives and designees of County, State, and/or federal governments.

3.3.2 Contract providers may have a paper clinical record or an EHR providing it meets all requirements of the Short-Doyle/Medi-Cal Organizational Provider's Manual (Organizational Provider's Manual), this Policy, and DMH Policy No. 104.09. (References 4 and 6)

3.3.3 For Directly-Operated billing providers the official clinical record is a paper clinical record, with the exception of those facilities which have a LAC-DMH approved EHR.

3.3.4 For those Directly-Operated billing providers with an approved EHR, the EHR is the official clinical record.

3.4 For Directly-Operated programs, all clinical documentation within the clinical record must be on clinical forms approved by the Quality Assurance Division of LAC-DMH with the exception of standardized screening/measurement tools and Evidence-Based Practice worksheets.

3.5 Contract Providers must use LAC-DMH approved clinical forms in a manner defined by the designation of the form within the Clinical Forms Inventory. (Reference 2)

3.5.1 LAC-DMH Required Clinical Record Forms may **not** be altered in content, format, or structure by Contract Providers who use paper clinical records. Contract Providers who use EHR, all data elements (excluding simple prompts) on LAC-DMH Required Clinical Record Forms must be present in the EHR and the Contract Providers must be able to produce a printable e-report that replicates the existing LAC-DMH Required Clinical Record Forms data elements and sequence or they must be able to produce the LAC-DMH defined clinical XML Messages.

3.5.2 For LAC-DMH Required Data Elements Clinical Record Forms, Contract Providers who use paper clinical records must maintain all required data elements present in these forms although the layout and presentation of the forms may be altered. Contract Providers who use EHR must maintain all required data elements of these forms within the EHR.

3.5.3 For LAC-DMH Optional Clinical Record Forms, Contract Providers with a Paper Clinical Record or an EHR must have a method of capturing the specific category of information that is indicated by the title and data elements of the form.

3.5.4 For LAC-DMH Ownership Clinical Record Forms, Contract Providers with a Paper Clinical Record or an EHR must have a method for complying with all laws/regulations encompassed by the forms.

PROCEDURE

4.1 All Directly-Operated programs must follow the procedures set-forth in this section.

4.2 All clinical documentation (documentation of direct services and supporting direct services including progress notes, medication notes and any other supporting documentation) must be completed and filed in the clinical record by the end of the next scheduled work day following the delivery of service unless specific exception is made by the program manager or their designee prior to submission of claims for reimbursement.

4.3 All clinical correspondence and correspondence received from outside sources related to a client must be filed in his/her clinical record within five (5) working days of receipt and must minimally contain the client's full name.

4.4 Clinical documentation and clinical correspondence shall not be kept or stored (paper or any electronic medium other than an EHR) outside of the clinical record.

4.5 Clinical documentation and clinical correspondence may be saved while in the process of being completed or while awaiting supervisory approval but must immediately be printed-out after completion, filed in the clinical record, and deleted from the electronic medium in accord with the timeframes identified in Section 4.2 of this policy.

4.5.1 While in the process of completing an assessment that takes multiple service contacts, the partially-completed assessment form must be placed in the clinical record, along with a progress note documenting the assessment-related service provided that day, within the timeframes identified in Section 4.2 of this policy. When information is to be added to a saved assessment form prior to finalization, the form must be replaced in the clinical record with the updated version and a progress note referencing the added sections must be filed in the clinical record in accord with Section 4.6 of this policy.

4.6 Once filed in the clinical record, all documentation is considered final and may not be altered.

4.6.1 If clarification or additional information is needed, it may be added provided that there is clear documentation referencing when the information was added and by whom.

4.6.2 If a documentation error is made, a single line-through should be made with the words "mistaken entry" noted next to the line through. The staff person making the correction must initial and date the correction and, when appropriate, the correct information should be charted close to the mistaken entry.

4.7 The contents of the clinical record must be firmly attached to the clinical record and filed according to the LAC-DMH approved chart order.

4.8 Clinical records shall minimally contain the following clinical forms (See DMH Policy No. 104.09 and the Organizational Providers Manual for additional requirements) unless specific exception has been made by the DMH-Clinical Records Director:

- MH 601-LAC-DMH Notice of Privacy Practices: Acknowledgment of Receipt Form;
- MH 500-Consent for Services;
- MH 635-Advanced Health Care Directive Acknowledgement Form (clients 18 years and older only);
- MH 612-Account Tracking Sheet;
- MH 224A-Client Face Sheet; MH 281-Payer Financial Information (PFI), MH 224B-Open and Close Episode forms;
- An Assessment on a LAC-DMH approved Assessment form;
- A Client Care Plan, if applicable per DMH Policy No. 104.09;
- Progress Notes/Medication Notes per DMH Policy No. 104.09;
- MH 556-Outpatient Medication Review form(s), if applicable per DMH Policy No. 103.01; and
- MH 517-Discharge Summary, if applicable per DMH Policy No. 104.05.

4.9 Clinical records shall not contain the following information:

- Raw data from psychological testing
- Administrative documents for the internal use of the program
- Critical incident reports/investigations
- Suspected abuse reports
- Staff conflicts and disagreements
- Staffing and workload problems
- Other clients' full name(s)

4.10 The clinical record must be complete, accurate, current, and legible.

4.11 A signature, the provider's type of professional degree, licensure, or job title, and the relevant identification number (for Progress Notes), if applicable, must be present on all documentation. Refer to the Organizational Provider's Manual for more information. (Reference 4)

4.11.1 The identification number is the provider's license, registration, certification or waiver number, as issued by the Licensing Board or, in the case of waivers, by the State of California when applicable.

4.12 The client's name and IS number must be on all clinical forms in the chart.

4.13 If abbreviations are used, they should be standard, industry-accepted abbreviations.

4.14 All documentation in the clinical record must be in English.

4.14.1 Whenever non-English forms are used or non-English documentation is completed, an English version must be attached to the non-English version.

AUTHORITY

1. California Code of Regulations, Title IX, Chapter 11, Medi-Cal Specialty Mental Health Services
2. 45 Code of Federal Regulations, Section 164, Security and Privacy

REFERENCES

1. DMH Policy Nos. 500.01-500.28 address various aspects of Health Information Portability and Accountability Act (HIPAA) safeguarding of PHI.
2. Clinical Forms Inventory
3. Clinical Records Guidelines
4. DMH Policy No. 104.09, Clinical Documentation for Medi-Cal and non-Medi-Cal/ non-Medicare Services
5. DMH Policy No. 104.10, Medicare Clinical Documentation
6. Short-Doyle/Medi-Cal Organizational Provider's Manual
7. DMH Policy No. 103.01, Standards for Prescribing and Furnishing of Psychoactive Medications
8. DMH Policy No. 104.05, Closing of Service Episodes

RESPONSIBLE PARTY

LAC-DMH Program Support Bureau, Quality Assurance Division